STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING 01 B. WING	01/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN 47660

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/03/13 Facility Number: 000327 Provider Number: 155561 AIM Number: 100273920 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Good Samaritan Home and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with two separate basements was	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Posr Survey Revisit on or after January 23, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on both levels including the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 86 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the physical therapy closet and the Activity Office closet in Station 3, plus three detached sheds, one wood and two metal, used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/09/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure a handrail was provided for 1 of 3 exits with ramps. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. Exception No. 3 says existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect up to 28 residents, as well as staff and visitors during an evacuation through the Chandelier Dining Room exit doors. Findings include: Based on observation on 01/03/13 at 11:45 a.m. during a tour of the facility with the Maintenance Director, the Chandelier Dining Room exit had a sidewalk/ramp forty feet long with a grade change of more than one foot from top to bottom which	K0038	1. No residents were affected and both alleged deficiencies have been corrected. Alleged deficiency # 1 has been corrected. A handrail has been constructed and installed on 1 side of the existing exit ramp leading out of the Chandelier Dining Room. Alleged deficient practice #2 has also been corrected. All 15 access controlled egress doors with locking devices connected to the fire alarm system now automatically release when the fire system is actuated. The 8 doors that were corrected were the station 3 south exit doors, Chandelier Dining Room exit doors, station 2 south exit door, interior set of double doors seperating the two sections of station 2, and the single interior door seperating the south section of station 2 from the Chandelier Dining Room.2. Twenty-eight residents as well as staff and visitors could be affected by deficiency #1. Forty residents as well as staff and visitors could be affected by alleged deficiency #2. A handrail has been constructed and installed on 1 side of the existing exit ramp leading out of the Chandelier Dining Room. Alleged deficient practice #2 has also been corrected. All 15	01/23/2013

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	was not provided with a handrail on either side. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 8 of 15 access controlled egress doors with locking devices connected to the fire alarm system, automatically unlocked when the fire alarm system was actuated. LSC Section 19.2.1 refers to LSC Chapter 7. LSC 7.2.1.6.2(d) requires activation of the building fire protection signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire protective signaling system has been manually reset. This deficient practice could affect 40 residents, as well as staff and visitors in Station 2 and Station 3. Findings include: Based on observations on 01/03/13 between 12:20 p.m.		access controlled egress doors with locking devices connected to the fire alarm system now automatically release when the fire system is actuated. The 8 doors that were corrected were the station 3 south exit doors, Chandelier Dining Room exit doors, station 2 south exit door, interior set of double doors seperating the two sections of station 2, and the single interior door seperating the south section of station 2 from the Chandelier Dining Room.3. A handrail has been constructed and installed on 1 side of the existing exit ramp leading out of the Chandelier Dining Room. Alleged deficiency #2 has also been corrected. All 15 access controlled egress doors with locking devices connected to the fire alarm system now automatically release when the fire system is actuated. The 8 doors that were corrected were the station 3 south exit doors, Chandelier Dining Room exit doors, station 2 south exit door, interior set of double doors seperating the two sections of station 2, and the single interior door seperating the south section of station 2 from the Chandelier Dining Room.Maintenance supervisor, ED/designee will ensure all newly constructed exit ramps be equipped with 2 handrails. Maintenance supervisor will increase frequency of day shift 5 panel testing to weekly for 6 months to ensure all	

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	and 12:35 p.m. while testing the fire alarm system during a tour of the facility with the Maintenance Director, the Station 3 south exit doors, Chandelier Dining Room exit doors, Station 2 south exit door, the interior set of double doors separating the two sections of Station 2, and the single interior door separating the south section of Station 2 from the Chandelier Dining Room entrance corridor were locked against egress and equipped with access controlled egress doors with magnetic locks connected to the fire alarm system. The only way to exit these doors was to actuate the fire alarm system or press a five digit code on the keypad next to the doors, however, when the fire alarm system was actuated three times, these doors did not release from the magnetic locks automatically. This was acknowledged by the Maintenance Director at the time of each fire alarm test. 3.1-19(b)		15 doors automatically release when fire alarm is actuated. ED will sign off on all 5 panel testing for 6 months. 4. Maintenance supervisor, ED/designee will ensure all newly constructed exit ramps be equipped with 2 handrails. Maintenance supervisor will increase frequency of day shift 5 panel testing to weekly for 6 months to ensure all 15 doors automatically release when fire alarm is actuated. ED will sign off on all 5 panel testing for 6 months. Results of all 5 panel testing will be forwarded to CQI monthly for review and recommendation if needed.	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide an automatic sprinkler system to ensure complete coverage in 2 of 6 smoke compartments. This deficient practice could affect 28 residents, staff and visitors in the two smoke compartments of Station 3. Findings include: Based on observations on 01/03/13 at 11:10 a.m. and again at 11:25 a.m. during a tour of the facility with the Maintenance Director, the Physical Therapy cushion closet in the Station 3 north section, and the Activity Office closet in the Station 3 south	K0056	1. No residents were affected and the alleged deficiency was corrected. Sprinkler heads were installed into both the physical therapy closet and the activity office closet in the station 3 south section.2. Twenty-eight residents including staff and visitors have the potential to be affected by the alleged deficiency. Sprinkler heads were installed into both the physical therapy closet and the activity office closet in the station 3 section.3. Maintenance supervisor audited all areas of the building to ensure sprinkler heads were in place in all required areas. Sprinkler heads are in place in all required areas.4. Safety meeting/CQI meeting held monthly will include review of any planned new contruction or remodeling projects to ensure sprinkler heads are installed in all required areas.	01/23/2013

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	section were not provided with sprinkler heads. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)			

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K0130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to document the maintenance of 51 of 51 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of battery operated smoke detector documentation in the Life Safety Code Documentation book on 01/03/13 at 9:15 a.m. with the Maintenance Director present, the written record for testing battery operated smoke detectors in all 51 resident rooms only included the day of the month the smoke detectors were tested. It did not include an itemized list of each room where battery operated	K0130	1. No residents were affected and the documentation deficiency has been corrected. A complete check of all 51 battery-operated smoke detectors has been performed and individually documented on the Battery-Operated Smoke Detector Maintenance Log to ensure the smoke detectors are all properly working.2. All residents including staff and visitors have the potential to be affected by the alleged deficiency. A complete check of all 51 battery-operated smoke detectors has been performed and individually documented on the Battery-Operated Smoke Detector Maintenance Log to ensure the smoke detectors are all properly working.3. Maintenance Supervisor has been in-serviced by Executive Director on the proper form and policy of documenting battery-operated smoke detectors. Battery-Operated Smoke Detector Maintenance Log is now being used to ensure appropriate documentation is performed with each check. ED will sign off monthly for 6 months on all Battery-Operated Smoke Detector Maintenance Logs. 4. All Battery-Operated Smoke Detector Logs will be brought to monthly safety/CQI meeting to check for proper documentation	01/23/2013

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	smoke detectors were located and a pass or fail result for each smoke detector. At the time of record review the Maintenance Director said all resident room battery operated smoke detectors were tested each month, however, only the date of the tests was recorded. Based on observations on 01/03/13 during the tour of the facility with the Maintenance Director from 10:30 a.m. to 12:45 p.m., battery operated smoke detectors were observed in all resident rooms. 3.1-19(b)		of all 51 battery-operated smoke detectors.	